Legal Issues

By Janet K. Feldkamp, JD, RN, LNHA

Nursing Facility Contractual Agreements Deserve Close Attention

The agreements that most long-term care facilities have with vendors of goods and services can pose unique legal and regulatory concerns. Contracts for such items as food staples, durable medical equipment, medical supplies, therapy services, pharmaceuticals, and laboratory and x-ray services can be the basis for significant liabilities, especially when an agreement becomes the subject of a fraud and abuse investigation.

Historically, nursing homes have not been major targets of prosecution in this area, but the increasingly aggressive enforcement climate could be changing that. Because reimbursement and legal landscapes are changing, facilities need to stay abreast of these issues and periodically review their vendor agreements to ensure that they meet current requirements.

A recent federal court case demonstrates how a vendor contract can cause legal headaches for a nursing facility. Earlier this year, a federal district court in Illinois allowed a False Claims Act illegal-kickbacks case to proceed.

In United States v. McKesson Corp., the government filed a civil lawsuit against the pharmaceutical and medical-supplies distributor's affiliate MediNet, a billing agent, and a nursing home for including illegal kickbacks in deals made between the two in 2003 and 2006. In both instances, MediNet is accused of reducing its fees below fair market value to obtain durable medical equipment referrals from the facility for McKesson. The facility is accused of "dangling" the referrals for McKesson in order to induce MediNet's discounts.

Whether or not the government's claims will prevail remains to be seen. But the 8-year-old case already has been inconvenient and expensive for the accused facility and the vendor. The litigation has required 60 witness depositions, thousands of pages of discovery documents, and expensive legal fees.

In another example from this summer, a Pennsylvania man was charged by the government with fraud in an ambulance scheme. He is alleged to have billed Medicare for ambulance transports that were not medically necessary and thus not covered services. The indictment seeks a forfeiture of $5,443,315, and the man faces jail time and a fine of up to $250,000, if he is convicted.

This type of fraudulent conduct should be important to nursing homes because LTC facilities that make service arrangements with ambulances or other vendors can wind up in trouble too. Facilities that negotiate high-volume or favorably-priced contracts and that know, or should have reasonably known, of the illegal vendor activities may be drawn into fraud lawsuits under conspiracy or aiding-and-abetting charges.

In addition to creating fraud and abuse troubles, contractual arrangements can raise regulatory issues. Federal and state laws place certain requirements on business transactions involving health care organizations and individual care providers. Facilities should keep a close eye on their compensation and reimbursement arrangements. Issues such as bundled Medicare billing requirements for skilled nursing facilities and the good standing (or not) of employees warrant careful attention when reviewing contracts.

For example, in 2009, Margaretville Hospital and Margaretville Nursing Home in New York self-disclosed inappropriate pharmaceutical billing practices to the Office of Inspector General (OIG) within the Department of Health and Human Services. In acting as the nursing home's pharmacy, the hospital billed Medicare Part D drugs for the nursing home even though the drugs were already paid for under Medicare Part A. The facilities agreed to pay $80,000 for the billing practices. Nursing homes need to be vigilant about billing for their services, even in situations where the facility is not the entity directly responsible for billing others.

In 2008, Skilled Healthcare in California paid about $190,000 to the OIG for employing excluded individuals in nine separate LTC facilities that the company managed. Facilities violate federal law whenever any employee, from clinicians to administrative staff, has been excluded from participating in federal health care programs. Again, facilities need to monitor their vendor and other contractual arrangements so they are not implicated in any questionable billing practices.

Because they are subject to strict regulations and laws, nursing homes and skilled nursing facilities need to be vigilant when entering into and maintaining their contracts with vendors. Some suggestions for keeping on top of contracts and vendor arrangements:

- Identify and scrutinize any arrangement that involves a physician or referral source. Watch for potential violations of federal laws against kickback arrangements and against the provision of services for rates below fair market value.
- Identify discounted or free items and other incentives in arrangements and make sure they do not violate federal or state anti-kickback law.
- Ensure that vendors and their employees and subcontractors are not excluded from participating in federal health care programs for violations such as engaging in health care fraud, patient neglect or abuse, and felony conviction related to the manufacturing or selling of controlled substances. Upon entering into an agreement, a facility should verify that a contractor or vendor is not excluded and check that the vendor has plans to monitor its employees' exclusion statuses. The facility should itself also periodically look into vendor compliance. The OIG website has additional information on exclusion from federal programs: http://exclusions.oig.hhs.gov.
- Identify agreements in which the vendor occasionally bills Medicare or Medicaid directly. The arrangement may violate the anti-kickback statute when different billing methods are strategically used to the economic benefit of the billing parties.
- Know that certain arrangements create special issues. For example, skilled nursing facilities and dialysis providers must structure their agreements to meet specific regulatory requirements. Arrangements between hospitals and assisted living agencies must also meet specific criteria.
- Review contracts to make sure they are signed, dated, and not expired.
- Develop a plan of periodic review to ensure ongoing compliance of your vendor agreements and other contractual arrangements.

This column is not to be substituted for legal advice. The writer, Janet K. Feldkamp, practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, Ohio.

Rule Supports Value-Based Payments

Medicare • *from page 1*

The postdischarge transitional care services plan was part of the 2013 Medicare Physician Fee Schedule proposed rule, which was released July 6.

But the fee schedule proposal is not all good news. The proposed rule also details the 27% across-the-board cut to physician fees scheduled to take effect on Jan. 1. The reduction is required by law, based in part on spending targets set under the Sustainable Growth Rate (SGR) formula, which links fees to changes in the gross domestic product.

Under the proposal, CMS also is seeking to expand its multiple-procedure payment reduction policy to diagnostic tests in both cardiology and ophthalmology.

Starting in January 2013, there would be an across-the-board reduction of 25% to the technical component for second and subsequent procedures performed by the same physician or physicians in the same group practice for the same patient on the same day. The cut will not apply to the professional component of the fee. The proposed rule lists 131 diagnostic cardiovascular services that would be subject to the multiple-procedure payment reduction policy.

Dr. William Zoghbi, president of the American College of Cardiology, said the reductions would be bad for both physicians and patients.

"This policy disadvantages physicians who aim for efficiency [and] would lead to a major inconvenience to patients."

The 2013 fee schedule proposal also outlines the implementation of the physician value-based payment modifier, which adjusts physician payments based on the quality and cost of care they provide. The program, which was mandated under the Affordable Care Act, will be phased in over 3 years starting in 2015.

The proposed rule also would implement the physician value-based payment modifier for all medical groups with 25 or more eligible providers starting in 2015.

Groups that do not participate in the Physician Quality Reporting System would see a 1% cut in Medicare payments. Groups that do participate would be paid in part based on their performance. Groups with higher quality and lower costs would be paid more, and those with lower quality and higher costs would be paid less, according to CMS. The payment adjustments made in 2015 will be based on 2013 performance in the PQRS.

CMS published the proposed rule in the Federal Register on July 30, and it will accept public comments until Sept. 4. The agency plans to finalize the physician payment rule by Nov. 1.

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